SEPTEMBER 1957

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Mental Hospitals

Volume 8
Number 7

CONTENTS, SEPTEMBER, 1957*

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THIS MONTH'S COVER

The cover picture, taken by the author at Warlingham Park Hospital, Croydon, England, shows a patient-guide pointing to a small section of the wrought iron fence which originally surrounded the grounds. This section was deliberately left standing as a reminder of how things were before the hospital adopted the "open-door" policy.

Early this year, a group of six New York state hospital directors were appointed by Dr. Paul H. Hoch, the very active Commissioner of Mental Hygiene, to spend almost a month abroad, studying the new patterns of mental hospital management which are now emerging in Great Britain. The study was made possible by a grant from the Milbank Memorial Fund. The purpose was to determine whether the principles underlying the new trend could be applied to the New York state hospital system. But, realizing that the implications of this study are of significance to all American mental hospitals, Dr. Hoch was kind enough to make available to MENTAL HOSPITALS brief reports specially written by each of the six directors.

The authors, experienced hospital psychiatrists, must have approached the open-door hospitals with a good deal of healthy skepticism. They asked many questions. How have the British achieved the open-door? How have they integrated the mental hospital with community services? How does this work in practice? Why the recent huge increase in voluntary admissions (80-95% in some places)? How does a large city cope with the administrative problems of providing mental health services? Why has the British program been so successful? Above all, which of these British practices are based on local circumstances, and which on principles also applicable in this country?

That the initial skepticism disappeared will be quickly evident to the reader, yet the authors have not, in this presentation, pretended to tell the whole story. Numerous explanations are offered for the success of the program, but one important factor which receives comparatively little attention is mentioned by Lothar B. Kalinowsky, M.D., in the December 1956 *American Journal of Psychiatry*.

Dr. Kalinowsky writes: "European hospitals work under incomparably better conditions than ours. For one, there is no shortage of well-trained psychiatrists. Private practice is no incentive for doctors trained in psychiatry. The English hospitals benefited from the National Health Act because prominent practicing psychiatrists are now paid for consultations in mental institutions. Thus both full time and part time work in mental institutions became more desirable."

I would like to conclude by saying that the generosity of the Milbank Foundation and the imagination and foresight of Dr. Hoch in sending six hospital psychiatrists abroad, and the consequent practical applications of their findings, as indicated in the following reports, is to me the fruition of a thought I expressed in closing the discussion of Dr. Kalinowsky's paper more than a year ago:

"I can think of no wiser expenditure of Foundations' funds than to set up a series of travelling scholarships for qualified and deserving hospital superintendents, clinical directors, or staff members, providing them with 3 to 6 months' study abroad in some of the hospitals described in this paper. The rewards in improved hospital treatment methods and broadened approach would be immeasurable. I trust the Foundations are listening."

I hope the Foundations continue to listen.

ZIGMOND M. LEBENSOHN, M.D.
Washington, D. C.

OBSERVATIONS ON THE BRITISH "OPEN" HOSPITALS

A month-long study of British "open" mental hospitals by six New York state hospital directors has resulted in an accelerated program of opening wards in New York state hospitals. The following articles represent highlights specially prepared for MENTAL HOSPITALS by the members of the study group who wrote the official New York state report.

INTRODUCTION

By PAUL H. HOCH, M.D., Commissioner of Mental Hygiene, Albany, N. Y.

THE State of New York Department of Mental Hygiene has for some time followed with great interest the development of a new philosophy in the treatment of the mentally sick in a number of European countries and especially in Great Britain. The philosophy now in practice is generally known as the open-door policy. This means that the patients are not locked in, that there are no bars on the windows, and that the patients can move freely in the hospital so far as their condition permits. In other words, there are no more restrictions placed on patients than is customary in general hospitals or other open treatment facilities.

It has to be emphasized of course, that the open-door policy does not start and stop with the open door. It is, however, the most outstanding symbol of the new philosophy. The open-door policy means more than an open hospital. It means a good relationship between the hospital and the community; it means tolerance of the community towards the mentally sick; it means integrated and coordinated psychiatric services. Without the confidence and support of the community, an open-door hospital cannot be established.

Until very recently the treatment of the mentally ill was overshadowed by administrative and legal considerations. To some extent, this was because no treatment procedures existed which restored many patients to the community. At present more and more treatment methods are available which accomplish this purpose.

The present treatment methods alleviate to a large extent the restraint which has been used on disturbed and excitable patients. In many hospitals today patients under treatment do not behave differently from patients who are not mentally sick. The open hospital reinforces the results which are accomplished with the newer psychiatric treatments. It also eliminates the stigma which is still attached to mental disease and mental hospitals. What is most important, it permits a patient to receive treatment in a dignified way and in a way which is human. The approach to the mentally sick was shot through for many centuries with security measures and with punitive intents. Only a comparatively short time ago was it realized that mental disorders are sicknesses, to be treated the same way as any other disorders.

The following descriptions of mental hospital management in Great Britain present a vivid example of how hospitals can be transformed from closed restrictive places to open, free and therapeutically effective installations. Some of the features described in the reports apply more specifically to British hospitals, since in many ways American hospital organizations and legal procedures differ from the British. Nevertheless, the basic idea—to treat these patients with the most effective therapeutic measures available in a dignified, nonpunitive fashion—is as applicable to the United States as to Great Britain.

Some of the administrative features and other aspects will have to be worked out and adapted to our special needs, but I have no doubt that, just as we are developing more and more effective treatments for the mentally sick, we will also develop a more effective kind of hospital organization to carry out this treatment in an atmosphere which will be helpful to the patient instead of harmful.

PART I

SUMMARY OF FINDINGS

By ROBERT C. HUNT, M.D., Director, Hudson River State Hospital, Poughkeepsie, N. Y.

THE OBSERVATIONS which follow were agreed upon by the entire group; they are presented as generalizations about those selected programs which were observed without any suggestion that they would be valid for any other programs, or for British mental health practices in general. Indeed, the recently published "Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency"* calls for some much-needed reforms before British hospital psychiatry as a whole can reach the standards set by the outstanding hospitals which our group visited.

The report perhaps places undue emphasis on the open-door policy in mental hospitals. If so, it is because the open-door policy is the most daring symbol of, the most vivid embodiment of, and the best descriptive vehicle for the basic philosophy which animates the whole complex of mental health services in the better British programs.

The completely open mental hospital is a reality. We inspected two hospitals which are entirely open, and two others which have recently begun the process and are now respectively about three-fourths and one-half open. We encountered multiple evidences that the open-door policy is becoming fashionable and is spreading rapidly in Britain. These are not special hospitals for selected cases; each is responsible for all the mentally ill in its district, and its continued treatment service is populated by patients with far advanced chronic psychoses.

The open door has considerable therapeutic value per se, but it is to a large extent a symbol of other values. The open door cannot stand alone, but must be backed up by an active treatment program by a psychiatrically oriented staff. It is also greatly facilitated by a good community program which provides continuity of care for the patient in and out of hospital, and early initiation of treatment in the community.

There appears to be a consistent relationship between the open hospital regime and more normal behavior by patients. In the two hospitals which have been open for several years virtually no acting out was seen. In one which began to open its door three years ago, and still has some closed wards, the patients were quiet and well behaved, but showed more tension and lack of rapport than did patients in the hospitals with a longer history of the open-door policy. In one which made its first move toward open doors in the past year, and is only about half open, we observed gross agitation, disturbed conduct, and screaming among patients on the wards still closed.

It should be stressed that the open door is symbolic of a total attitude of tolerance and permissiveness both in the mental hospital and in the community. In the most advanced programs there appears to have been an almost complete abandonment of compulsion as an instrument for the hospitalization and treatment of the mentally ill. In this permissive framework there is a high degree of voluntary cooperation by patients.

It should also be stressed that the open-door policy is not one of licensed disorderly anarchy. There are full activity programs which keep most of the patients busy. While many of the patients come and go without supervision, nursing staff is concentrated on directing the activities of the more regressed and confused patients. Patients assume much responsibility for both their own conduct and that of others, the less responsible being watched over by the better ones. In one hospital the most regressed wards are subdivided into groups of about 10 patients, each group permanently assigned to one nurse who works with the group throughout all its daily activities, feeding, bathing, occupational therapy, habit training, etc.

The law and practices concerning the discharge of patients show the same permissiveness and diffusion of responsibility as seen in hospital operation. The law provides that on demand by the next of kin, a certified patient *must* be discharged within three days, unless the superintendent executes a special certificate that the patient is dangerous and unfit to be at large. This is generally interpreted quite liberally. Very few patients are denied a requested discharge, and many quite ill patients are released, with the responsibility for the release borne by the family rather than by the superintendent.

British mental hospitals are plagued by commitment of patients by criminal courts under restrictive orders. Some hospitals have successfully refused to impose upon such patients any security measures which would interfere with therapeutic aims.

Physicians and ward personnel place comparatively little emphasis on "administration," and medical and nursing records are very brief and sketchy by our standards. They appear to have more time for personal contact with their patients. The open-door regime saves the nursing service much time which would be used in carrying out custodial and security measures such as conducting patients to work assignments, counting in and

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* *A recent debate in Britain's House of Commons upon the Report makes it clear that the medical and legal professions in Great Britain are far from satisfied with the existing legislative provisions for voluntary and compulsory "certification" and the operational aspects of discharging patients. The Report, now under study, recommends considerable revision of the present status "to protect the liberty of the subject."*

out, etc. At the same time it more urgently requires the nurse to know her patients intimately, to observe and report any change which may require attention. The relative freedom from security and administrative routines makes it possible for the nurse to carry out professional nursing service more adequately. Physicians also appear to spend a great deal of time on the wards and to have a close working relationship with both patients and nurses.

The intimacy of relationship is probably in part a result of the generally small size of ward units. In four large mental hospitals we saw only two wards with 50 or more patients (one with 83). Most wards have less than 40, and some, 20-30 patients.

In British mental hospitals there is no class of personnel equivalent to our attendants. All ward personnel responsible for patient care have professional training, professional status, and the professional title of Registered Mental Nurses (or are student nurses working for their R.M.N.). Housekeeping chores are performed by porters and orderlies who have no responsibility for patients. The R.M.N.'s are considered specialists, and receive higher pay than do Registered Nurses employed in mental hospitals. The total ward activity program centers around the nurse, not only on the ward, but also in occupational and recreational activities outside the ward.

A striking feature of all hospitals visited was the physical appearance of the wards with their household types of furnishing. There were invariably rugs, drapes or curtains, upholstered furniture, bedspreads, vases of flowers, and colorful paint or wallpaper. Even on the most regressed wards of the most neglected hospital the shabby old furniture was comfortable and homelike. No benches or hard wooden chairs were seen anywhere. This appears to be standard despite abundant evidence of scanty financial resources for maintenance and equipment. In some of the best hospitals there is a corresponding attention to patient's clothing and grooming and most patients cannot be identified as such by their personal appearance.

The better mental hospitals have a close liaison with the communities in their "catchment areas," although under the official legislative system the hospitals have no authority or responsibility to do community work, which is the job of the local health authority. In practice, however, hospital staffs working in collaboration with local health officers provide a complete range of community services, including observation wards, adult and child guidance clinics, day hospitals, aftercare clinics, rehabilitation services, and home consultation services (domiciliary visits). Part of the reduction in the population of some mental hospitals, especially as regards the aged, appears to be due to these methods of providing care in the community.

Especially striking is the range of services available for the elderly in the community. Much is done to keep such patients at home, even when they live alone, by visiting nurse services, "meals on wheels," and enlisting the help of neighbors and relatives. Grossly ill seniles are transported to and from day care centers. Others are placed in "Part III Accommodation Welfare Homes," similar to our nursing homes. General chronic disease hospitals give care during more acute episodes and in terminal failure. Help is given by clinics, and in "Darby and Joan" clubs with the help of volunteers.

THE HOSPITALS VISITED

England

Warlingham Park Hospital, Croydon, Surrey
St. Thomas Hospital, London
Banstead Hospital, Surrey
Mapperly Hospital, Nottingham
Coney Hill and Horton Road Hospitals, Gloucester
Tooting Bec Hospital, London
Geriatrics Service, Cowley Road Hospital and Longworth Geriatric Residence, Oxford
Tavistock Clinic, London
Maudsley and Bethlem Hospitals, London
Marlborough Day Hospital, London

Ireland

Grangegorman, Dublin
Verville Retreat, Dublin

France

Ville Evrard, Paris

Efforts were made to learn what factors helped bring about the radical shift to voluntary admission of patients in British hospitals. The one factor which all authorities agreed on was the Mental Care Act of 1930 which legalized voluntary admissions. Most of the mental hospital superintendents stressed the importance of hospital staff going into the community. One of them stated that the 1930 Act had no immediate effect on his hospital. When he established his first community clinic in 1935, however, there was a sudden increase in voluntary admissions, which continued to increase to the present level of 95%. The open hospital and all it connotes has also played a part in dispelling resistance, in "destigmatization." One superintendent has all but eliminated certified patients by discharging them and readmitting them on voluntary papers, all with a stroke of the pen. One health officer gave credit to his Duly Authorized Officers for spreading the word, and one professor gave credit to the university training of graduate students. It was also remarked that the comparative rates of voluntary admission, published annually by the National Association for Mental Health, Inc.,* have become a standard by which hospitals are judged. It has become fashionable to strive for a higher rate by all available means.

* *The President of this British organization is the Right Honourable R. A. Butler, Secretary of State for the Home Department and Lord Privy Seal—a Cabinet rank. Among other functions, the organization undertakes responsibility for professional and public education on mental illness, mental health and mental deficiency, and administers certain residential facilities for the aged, the retarded and mentally disturbed and/or delinquent children.*

PART II

THE OPEN DOOR

By HERMAN B. SNOW, M.D., Director, St. Lawrence State Hospital, Ogdensburg, New York

WE MET some English psychiatrists who felt that the open door per se was a therapeutic process, which was in itself a great factor in the patient's recovery or improvement. Others, however, shared my own feeling that the open door is only one phase of the total treatment program of the hospital, and as such might be put on a par with electric shock, drug therapy or the ancillary services.

In general their consensus of opinion was that it was no improvement simply to replace inactivity behind a closed door by inactivity beyond an open door. Patients must have some form of purposeful activity which they may select voluntarily or in which the ward personnel must interest them. Only in this way does the open door have a purpose.

On the open wards we visited, there was very little tension to be observed among patients engaged in purposeful activity. I do not believe that similar activities on a closed ward would have released the patients' tensions in the same way. In general we found a fine, carefree sort of milieu in which people's liberties as well as their desires were respected.

We learned that our English colleagues had found the "opening" of a closed hospital a slow process. The most important single factor, they told us, was to have the personnel understand the aims of the new program. In each case some resistance from doctors, nurses and other staff members was encountered, but this was dissipated, either gradually or rapidly, as the purposes and benefits were seen. The program would then usually gain momentum rapidly, until the very last wards, usually housing the long term chronic patients, were opened.

In cases where staff resistance could not be overcome, because of ingrown attitudes, the personnel who could not go along with the program were removed either by resignation, retirement or by transfer away from the wards being opened. Initially, only selected patients were put on the open wards, depending on their reliability and mental condition. But as the program spread, and more and more wards were opened, patients, no matter what their condition, were never transferred but shared the benefits of the newly opened ward with their companions.

Partly to stimulate staff and patient interest, some hospitals set up special additional programs, especially for the long term chronic patients. After the ward was opened, electric shock, other forms of therapy, or even placebos were initiated. This made the personnel, as well as the patients, feel that there was something special going on, and made it easier to proceed with the opening up process.

The results of this opening up are apparent. In the hospitals we visited there was almost a complete lack of shouting, screaming, aggression and assaultiveness. Dr. Duncan MacMillan at Mapperly Hospital said "We just don't expect bad behavior on an open ward." Yet these were the identical patients who had previously been in restraint or been noted for their acting-out symptoms.

Opinion was divided about whether this change was caused by the open door per se, drug therapy per se, or a combination of both. I believe it was a combination of both. It appeared to us all, moreover, that the closed door and restrictions had apparently superimposed behavior symptoms and reactions on the patient which were not an inherent part of the mental illness for which he was hospitalized. It was these superimposed symptoms which disappeared when the doors were opened and the gratings removed from the windows. Moreover, as this program progressed the number of escapes and suicides as well as restraints decreased to almost negligible figures.

With less emphasis placed on confinement, discipline and administration, doctors and nurses on the wards appeared to become more psychiatrically oriented in their concern for the patient. The discipline on the wards changed from the authority type of hospital discipline to the patient group discipline, the group showing its disapproval or approval. When it was necessary to have a patient remain on the ward, either because of violation of rules or for other purposes such as treatment, he was simply instructed to do so. The patients obeyed regardless of the fact that the doors were open. Some patients walking around the grounds complained that they had been railroaded into the hospital, that they were being kept against their wishes and that they wanted their freedom, yet they never attempted to leave the hospital grounds and always returned to the ward. There seemed to be no special sex problems. The personnel felt that the patients handled their reactions in a more normal manner when fewer restrictions were imposed as to the mingling of the sexes.

At the time we went to England, the St. Lawrence State Hospital already had 65% of its wards open. I found that in England they had met problems similar to ours and that they had solved them in different ways because the local situations differed. On the other hand, I learned from them how to solve some of our own problems, and after I returned we proceeded to open additional wards. At present more than 90% are open. On the whole, we solved our problems in much the same way as they did theirs, always with necessary adjustments to the local situation.

As a result of the experience in England and at the St. Lawrence State Hospital, I feel that the success of the open-door policy depends on many factors—a small hospital, small wards, a stable employee population, psychiatrically oriented and trained personnel, the attitude of the Director, and the way this attitude is transmitted to his staff and the personnel of the hospital.

PART III

VOLUNTARY ADMISSIONS

By HYMAN PLEASURE, M.D., Director, Middletown State Hospital, New York

NEXT TO the open-door policy the most striking feature of the English mental hospital is the high percentage of voluntary admissions, which has reached 90% in some institutions. This is not an accidental or unrelated feature but is part of the picture of mutual respect and permissiveness which we find in the attitude of the hospital toward the mental patient and the attitude of the English public toward the mental hospital.

The voluntary admission did not exist in public mental hospitals in England until 1930 when the Mental Treatment Act was passed. The number of patients admitted voluntarily, however, was relatively low in most parts of the country until the establishment of outpatient departments staffed by mental hospital physicians. The National Health Act of 1946 fostered the extra-mural activities of the hospital physicians and thus caused a rise in the percentage of voluntary admissions. This Act placed the responsibility for all extra-mural psychiatric treatment in the hands of the local health officer, who, when he found that the only reservoir of psychiatric experience was in the mental hospital, appointed these hospital physicians to operate the clinics for which he provided quarters, social workers and clerical help.

Most of the patients in the community who require psychiatric treatment are known to the hospital psychiatrists, and have been under treatment long before they are admitted. A general practitioner who requires consultation for a psychiatric problem may call directly upon the mental hospital and the patient will often be seen in his presence by the hospital psychiatrist during a domiciliary visit. If he refers the patient to the nearest psychiatric clinic, this is usually staffed by the mental hospital and the psychiatric consultants in the general hospital will also be from the mental hospital. In some of these mental hospitals the senior physicians spend as much as half their time outside the hospital in community work.

The hospital psychiatrist has many methods of helping the patient before recommending hospital admission. He can, for instance, have him admitted to a general hospital psychiatric ward and continue the treatment himself or he can refer him to a day care center or to an outpatient clinic. He can assist the patient at home by providing "meals on wheels" and home visits by a public health nurse; he can refer him to an organization called "Remploy" for vocational training and rehabilitation. Finally, if he decides that the patient requires treatment in a mental hospital he can secure his cooperation by informing him truthfully that he is going to a hospital where the doors are open, where no treatment is given except with the patient's permission and where he can leave on 72 hours' notice. And if a patient replies "I don't know anyone at that hospital so far away" he can answer "I will take care of you there as I am the doctor," and occasionally even take the patient there in his own car when the clinic hours are over.

In London, where the voluntary admission rate is only 30%, this close contact does not exist, as the observation wards are staffed by psychiatrists from the medical colleges who seldom have time or inclination to urge the patients to seek voluntary admission. Dr. E. H. Charleton at Banstead Hospital in Surrey, serving central London, is aware of this weakness, and has established a 20-bed observation ward in London, many miles from the hospital, staffed by his own physicians, in order to control the entire treatment of the patient from the start and to have contact with the family doctor. The result of this system has been a marked increase in the percentage of voluntary admissions, a rise in the overall admission rate and a drop of 1,000 in the hospital census.

In Nottingham, at the Mapperly Hospital where there are 1,070 patients and 1,800 admissions per year, there is only one patient on legal certification. Dr. Duncan MacMillan accomplished this by going around the hospital and asking certified patients whether they would rather stay voluntarily and if so, having them sign a voluntary agreement. As a result of this trend, Dr. Aubrey Lewis complained that the high percentage of voluntary admissions, like the completely open hospital, has become a slogan that the hospitals like to boast about and are pushing beyond logical bounds, but Dr. MacMillan, Dr. T. P. Rees and others who are superintendents of such hospitals, feel that these features promote the patient's self-respect and are able to point with justice to a decrease in hospital population despite an increase in the admission rate.

The "non-statutory admission" is an interesting recent development which has marked a further step toward making the mental hospital more like a general hospital. Several hospitals have set aside wards or even separate buildings, called by an entirely different name from the main hospital, for this purpose. The aim is to destigmatize the patient's treatment, make admission more palatable and avoid having any record of the patient being certified to a mental hospital. These wards or buildings are staffed by the same nurses and physicians as the rest of the hospital but the patient does not sign any document and stays there as any patient might stay in a general hospital for treatment. The expenses come out of the same budget, that is, from the National Health Fund. Most of these patients are psychoneurotics, alcoholics and other non-psychotic mental patients who require residental psychiatric treatment for limited periods. In most places where we observed this system it was described frankly as an experimental program but it appears to be a natural extension resulting from the great emphasis on the voluntary and permissive nature of treatment such as we observed in the mental hospitals of England.


The devil

PART IV

PATIENTS' CLOTHING

By FRANCIS J. O'NEILL, M.D., Senior Director, Central Islip State Hospital, New York

THE OLD SAYING "Clothes make the man" is as applicable to the mental patient as to any other human being. Yet providing suitable clothing for the hospitalized mental patient has presented an almost insurmountable problem to the mental hospital administrator. The inadequate budgetary allowance for clothing in most hospitals has made it necessary for the institution to purchase many articles of clothing from prison industry, or to go into the manufacture of clothing. As a result of this, most state hospital patients in the United States are dressed in stereotyped, often bizarre, styles. The inability of prison or hospital industry to keep up with changes in clothing fashions has placed an indelible stamp on the appearance of the mental patient. Those patients fortunate enough to have interested relatives who provide them with modish clothing are the exception. These few patients readily stand out when one looks at the population of a mental hospital.

The present trend toward normalizing the day to day life of the hospitalized mental patient requires that special attention be given to the problem of providing adequate and stylish clothing. This applies especially to the female patient. Clothing has a high prestige value in our civilization and should be employed as a therapeutic tool in promoting recovery.

During our visit to the British mental hospitals, we were greatly impressed by the progress some of them had made in providing more adequate clothing for their patients. Warlingham Park provides one of the best examples of this improved situation. During the past several years, Doctor T. P. Rees and the business manager have worked together to improve the clothing, with the result that few of the patients seen at Warlingham Park could be recognized as mental hospital patients if seen on the street. This is unfortunately not true of the majority in our own hospitals.

Clothing Purchased Locally

Warlingham Park no longer makes clothing or purchases from prison industry. As far as possible, patients' clothing is purchased in local stores and nothing is accepted that is shoddy or out of style. A central clothing room is maintained. On admission each patient is given an allocation of clothing if he is unable to provide his own. He goes to the storehouse, where he chooses his suit, overcoat, hat, shoes, underwear, socks, shirts, ties and night clothes, from an assortment. The tailor treats him like a customer. Alterations are made where required. Every effort is made to cater to his individual taste. His clothing then becomes his property and is marked with his own name and a consecutive number. Later when clothes are sent to the laundry, they come back to the patient; at no time is he required to wear clothing which may have been previously worn by another patient. The wide range in style and color of women's clothing, too, was quite impressive, and I am sure that the newly admitted female patient at Warlingham Park did not feel that she was being given a handout when she went to the clothing room to select her wardrobe.

The open-door policy encourages the patient to take proper care of his clothing. Each is provided with a full length locker and has custody of the key. He is not required to hang his clothing in a common clothing room or put it under his mattress at night, as is often the case in some of our hospitals. The reduction in patient population as a result of the liberalized program has provided the room necessary for the individual patient lockers.

Dry Cleaning and Laundry Services Good

The British mental hospitals are fortunate in having an adequate dry cleaning service. A central plant is operated by the hospital authorities and pick-up and deliveries at the mental hospitals are made at regular weekly intervals. As a secondary result of the improvement in the clothing program, laundry services have become more carefully supervised. Most of the wards visited in several of the hospitals have laundry rooms, some equipped with electric washers and dryers to encourage both the male and female patients to launder their more delicate clothing. One of the barriers to the use of good fabrics in our hospitals has been its destruction in the mass laundry process. Certainly the patient who is adequately clothed and encouraged to look after his own clothing maintains a more normal interest in his appearance than when clothing is not individualized and all responsibility for its care is removed from him.

Undoubtedly improvement in the clothing program in our mental hospitals will increase the per capita cost. We attempted to make an evaluation of this at Warlingham Park and were startled to find that this cost has shown very little increase after the institution of the new clothing program. It is difficult to compare cost in Britain and America. It seems logical to suppose, however, that the improved care given to clothing by the patient and the hospital will tend to balance the increased purchase cost. From the therapeutic point of view, there can be no doubt that improvement in clothing and its handling will be well worth any amount of money expended in that direction.

Typical case: "unmanageable" schizophrenic patient is hostile, untidy and inaccessible to therapy.

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PART V

COMMUNITY CARE OF THE MENTALLY ILL IN A MEDIUM SIZED CITY

By C. F. TERRENCE, M.D., Director, Rochester State Hospital, New York

IN TWO of the medium sized cities that I visited, particularly in Nottingham, there is a very sincere effort towards early treatment of the mentally ill. This is accomplished through a variety of services that are available by the English psychiatrist in the community setting.

The local mental hospital is the nucleus of all psychiatric services, and as a matter of fact, while he has no official responsibility, the director of the mental hospital as a rule personally supervises the community care of the mentally ill. In Nottingham for instance, there is a mental hospital containing about one thousand beds, located centrally in the city, which serves all the psychiatric needs of that area. This hospital is truly an open hospital; the majority of the patients are admitted on voluntary application, and short-term intensive treatment for the newly admitted is provided. There are within the hospital very few senile or arteriosclerotic patients, because seniles, by and large, are cared for in the community or in day-care centers, or on a short-term basis in the general hospital.

I was particularly interested in the psychiatric and ancillary facilities available to the mentally sick of the city, particularly to the psychotic senile group. I saw the program in operation, for I had the privilege of accompanying Doctor MacMillan, the Director of the mental hospital at Nottingham, on his domiciliary visits.

The first patient we visited was a depressed, elderly lady who had been threatening suicide, and who on examination showed evidence not only of depression, but of confusion. Instead of immediate hospitalization, Doctor MacMillan afforded this lady a home-care plan which involved visitation on a daily basis by the nurse, on a bi-weekly basis by the Social Worker, and on a weekly basis by the District Health Officer; in addition she was to pay a weekly visit to the clinic of the local chronic general hospital. He arranged for her to be served with a midday meal by a service they call "meals on wheels". Thus some provision was made for the supervision of this patient, but in addition she will receive actual physical care almost comparable to hospital care.

A similar but more concentrated regime was prescribed for the second lady we visited, who was primarily confused and somewhat irritable. It was also arranged to transport her to a day care center where she would remain for about seven hours a day.

The third and fourth patients seen had problems that one is accustomed to see in the senile psychotic group—confusion, lack of interest in reality and a mild depression. Here, too, similar prescriptions were given. Note that Dr. MacMillan did not attempt to hospitalize this group of patients. One may quarrel with this attitude, and certainly by our standards hospital care would be almost mandatory (in two of these cases at least), because of obvious illness.

In both the Nottingham* and Manchester** areas it was obvious that the psychiatrist had a great deal of knowledge of the mentally ill in the immediate community. Also, the psychiatrist has the confidence of his District Health Officer, and between them they can work out almost any type of treatment plan to suit a particular problem. Thus patients are cared for in community centers, in welfare areas, day hospitals or in their own homes under relatively good psychiatric and nursing supervision. The chronic general hospital plays a big part in the treatment of the acute medical conditions, and undoubtedly relieves the mental hospital of the emergencies that are cared for in a psychiatric hospital in this country.

As far as I could see, good medical care is given to patients, and it serves as quite a challenge to those of us who insist on hospitalization of the senile and arteriosclerotic group of psychotic patients.

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* *Pop. 306,000;* ***pop. 703,200.*

PART VI

A COMMUNITY RESIDENTIAL FACILITY FOR THE AGED PATIENT

By NATHAN BECKENSTEIN, M.D., Director, Brooklyn State Hospital, New York

WE WHO ARE FACED with a constantly increasing admission rate of elderly patients, now comprising almost half of our first admissions, were interested in seeing what is being done with this problem in England. As we went through the various mental institutions, we noted that while they had an appreciable number of elderly mental patients, few of them were in bed. We learned that this was due to an active program of getting them up and out of bed as quickly as possible after their admission. We were informed, also, that the admission of these elderly patients had dropped in some instances to about one-third of what it had been previously, as a result of community programs for the aged. Naturally, we looked into these programs.

At the community level, there were such facilities as day care centers for the aged, outpatient clinics, day

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Indications: Acute schizophrenia, postoperative confusion, alcoholic psychosis, senile psychosis, other mental disorders characterized by dissociation or confusion.

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hospitals, observation wards in the chronic general hospital, and residential centers for the aged in public housing projects. It was my privilege to visit one of these residential centers, Braddock House, in the Nottingham area. Here was a unit consisting of single rooms, double rooms, and rooms with four beds, a common dining room and kitchen, and a common living room. There was easy access to the lawns in front of the house. Thirty-six elderly persons—18 men and 18 women—lived here. Mind you, these were forgetful, confused but quiet types, not merely elderly persons who were possessed of all their faculties.

In charge of the center was a matron who had some nursing training. She lived in the unit. She saw to it that the residents were properly dressed in accordance with the weather, that they ate their meals, which were prepared by a cook, that they were wholesomely occupied in their leisure hours, and that they got medical care when they required it. (With the English health insurance program, practically everyone has a doctor. Therefore each aged resident has his or her own physician available when needed.) Volunteers come in to visit or to conduct various activities with these elderly folk. Some were knitting or crocheting, others were weaving or playing games, such as cards, when we visited.

The old folks were able to continue for a long time doing many of the chores which they had done all their lives. For instance, during my visit I looked into a room with four beds. A woman in her late seventies had made the bed, dusted the dresser, and was sweeping the floor. Yet when I asked her, she told me the year was 1898, and that the day (actually Thursday) was Monday. Notwithstanding her mental symptoms, she was able to function usefully at her age in a community setting, under some supervision, and with a feeling that she was self-supporting. With her social security benefits, she was able to contribute something toward her maintenance, which cost much less than what it would have cost to maintain her in a mental hospital bed.

This type of facility is part of a broad mental program for the aged which has helped to decrease the number of these patients admitted to the mental hospital, and has allowed them to remain in the community, under good care, and, in most instances, for the rest of their lives.

YOU TOO CAN HAVE A TROUBLE-FREE HOSPITAL

By Dr. Whatsisname

ONCE UPON A TIME there was a superintendent who was determined to finish his career without ever having been subject to criticism. He knew others who had been raked over the coals because of suicides or homicides in their wards. He knew a superintendent who was denounced publicly because of an assault committed by a patient on trial visit. In his own ward-physician days he had been admonished because he allowed a patient to go out on a pass and then heard that the patient had made a scene on Main Street.

"Why stick your chin out?" was his motto today. "After all," he explained to his wife, "if I refuse a pass, no one but the family will criticize me. But if I allow a pass and something goes wrong, every legislator, alderman and police official in the community will want my head."

Sometimes a ward physician would enter the Presence and timidly suggest that yon deteriorated schizophrenic could safely be allowed out on the lawn. "No," answers the Superintendent . . . "See, right here in the chart, it says that in 1938, while out on the lawn, he got away from the attendant and chased a squirrel. After all, we have to protect ourselves against the charge of being lax. If the patient didn't need to be here, he wouldn't be here. And it's our job to protect him securely."

And so time marched on, and the Faineant State Hospital prospered. Its census rose and its *per diem* fell. The Superintendent was widely praised for running a hospital free of scandals, homicides, suicides, assaults—and also, alas, free of recoveries. And when the Superintendent died the flag in front of the Administration Building was half-masted, and the governor eulogized that here was a state hospital that never gave any trouble. The Superintendent was wafted straight to Heaven, for he had never stuck his chin out and thus no one had ever been able to hang anything on it.

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Supermarket Methods *Streamline* Pharmaceutical Dispensing

By K. WOOLCOCK, Chief Pharmacist, Provincial Mental Hospital, Essondale, B. C.

WHEN IT BECAME necessary to reduce the number of pharmacy personnel in order to curtail rising costs in our rapidly growing hospital, we undertook to streamline the entire pharmacy program. Our main problem was to maintain an uninterrupted flow of pharmaceutical and surgical supplies to the 17 patient buildings, each a fair-sized hospital in itself, on a five day a week basis.

In order to facilitate the requisitioning of pharmaceutical supplies, we drew up three lists of items that we felt were basic necessities on each ward and which could be safely ordered by the nursing staff. A number of the supplies included formerly had to be ordered by the physicians. The listed items, compiled from our inventory sheets, fall into three categories: surgical equipment, surgical sundries, and pharmaceuticals. Each type of list is printed on a different color paper and bound in pads of fifty. Only those items listed may be ordered by supervisory nursing staff; all else must be ordered on prescription forms signed by the attending doctor. By enabling the supervising nurses to requisition bulk quantities of pharmaceutical and surgical supplies not restricted by safety considerations, this system has saved considerable time for the physicians.

Supply Schedule Worked Out

Then we devised a schedule designating a "Drug Supply Day" for each area. Wards that have Monday, for instance, scheduled as their Drug Supply Day obtain their stock pharmacy supplies for the week by the following method: On Monday morning a delivery truck picks up the supply baskets from that area and brings them to the pharmacy. Later that day, after the baskets are filled, the truck returns them to the wards.

The original copy and one duplicate of each requisition list is sent to the pharmacy along with the supply basket; a third copy is filed on the ward. Empty containers are also returned in the baskets, and when the two pharmacist's aides receive the baskets the "empties" are set aside to be sterilized, refilled and relabelled for the next day's output.

The procedure we worked out for filling the supply baskets in many ways resembles shopping in a modern supermarket. All items were packaged into ward-size units and arranged on adjustable steel shelving surrounding the basket-filling area. The top of a sixteen-foot long cupboard and drawer unit provides work space where the baskets are lined up before and after being filled. To fill them, each pharmacy aide places one on a wheeled cart, like those used in actual supermarkets, and with the corresponding requisition in one hand he fills the basket directly from the shelves. The simpler surgical instruments, syringes, needles, catheters and the surgical dressings are taken from the drawers and cupboard unit.

Supplies Are Pre-Packaged

This system is quick, efficient and neat. The two aides can fill the day's orders by mid-morning and spend the remainder of the morning in re-stocking the area. The supply is pre-packaged in excess of immediate needs. Thus, should the demand be greater than usual for any item, there is less chance of having to disrupt the efficient "production-line" method of filling baskets. Even if one aide is off duty, the other can complete the job quickly.

By distributing the basic pharmaceutical supplies through this "supermarket" method, operated separately from the prescription department, we feel we have achieved a means of providing pharmacy service to the wards that is the utmost in efficiency.

Drug Inventory Kept on Card File

Each item stocked in the pharmacy at Richmond (Ind.) State Hospital is kept on 5 by 9 inch cards. The cards have columns for the *date, ward dispensed to, amount received* (i.e., stock replenishment), *amount used* and *balance*. After pharmaceutical requisitions have been filled, the items dispensed are posted on the proper cards and the amount used is subtracted from the previous balance. Whenever new supplies are received, they are credited in the *received* column and added to the previous balance.

This procedure not only serves as an inventory, giving the quantity on hand at all times, but is also a handy record of the distribution and usage of drugs and medical supplies. The latter feature is especially useful when ordering new supplies and helps prevent us from under- or overstocking.

Another device which we find useful in our pharmacy is to distinguish dangerous medications with a gold star on the label. These gold star drugs are ordered according to the amount used on the ward each day and require a physician's signature on the requisition.

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1. Shay, H., and Siplet, H.: Gastroenterology *32*:571 (April) 1957.
2. Dickes, R.; Schenker, V., and Deutsch, L.: New England J. Med. *256*:1 (Jan. 3) 1957.

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Problems of Opening A Rehabilitation House

By DONALD ELDRED, Psychologist, Vermont State Hospital, Waterbury

FOR SEVERAL YEARS the Vermont State Hospital has worked closely with the Vocational Rehabilitation Division of the Vermont Department of Education in the training, placement and other necessary phases leading to the return of carefully selected patients to the community as self-supporting and self-reliant people. This program had been slowly increasing but with the advent of the ataraxic drugs, the number of candidates for such help increased considerably. We were beginning to reach a group of patients whose illness had caused them to be hospitalized for long periods of time so that they had, in many instances, become strangers to their families and communities, or their home situations were unsuitable for them to continue their readjustment in the old settings.

We began, therefore, to explore the possibilities of providing the needed services on a group basis. Since the Rehabilitation Service had been able to pay the cost of training, maintenance and other expenses until the individual was earning enough to do so, it seemed that they might be able to finance a group program. The Vocational Rehabilitation Division was very much interested and presented the idea to the regional representative of the federal office of Vocational Rehabilitation. Approval was soon received from the federal office and was confirmed by the Vermont State Board of Education and by Governor Joseph Blaine Johnson.

News releases describing the plans were issued, and it was announced that the Vocational Rehabilitation Division was ready to lease a dwelling large enough to accommodate twelve or fourteen people. Several dwellings were offered and one was selected in the capital city of Montpelier. The lease was about to be signed when most of the residents of the neighborhood in which the house was located signed a petition protesting. Though various excuses were given such as unsuitability of the property for the patients, objection to removal of the property from the city tax list and thus increasing taxes for the petitioners, etc., the real reason was obvious.

Clergy Lends Support

Considerable newspaper and radio publicity followed and one of the ministers in the city delivered a very strong sermon against the prejudice shown by this petition. He was supported by one of the other clergymen in the city and subsequently by the annual convention of the Episcopal Diocese of Vermont. The reaction of the patients themselves was that it was up to them to show these people that former mental patients could be as good citizens as anyone else.

While the discussion continued and resolutions were passed in support of the project, another and even more suitable dwelling was offered on another street and a three-year lease with option to buy was signed. Later, the residents of this street presented a petition to Governor Johnson welcoming the patients and asking that their welcome be transmitted to the patients.

With the signing of the lease, the rehabilitation people also made an agreement with a married couple who had been working as attendants at the Vermont State Hospital. Under this agreement, the woman was hired to become house-mother and the man was free to continue his work but would be there often enough to serve as the "man of the house". Then followed purchase of furnishings for the house and many other details.

The women of the various churches in Montpelier provided window drapes, bedspreads, pictures, flowers, etc. The Women's Club presented three table model radios; many other types of assistance, tokens of interest and support have been received, including money given by hospital employees to purchase a TV set for "our friends at the Rehabilitation House".

Pre-Placement Sessions Held

In the meantime, in January 1956 several women patients who seemed likely to be the first to go to the Rehabilitation House were brought together on one ward. They began group therapy sessions twice weekly, were granted additional privileges and freedom, and were placed in work at the hospital and staff members' homes. They were interviewed periodically by one of the Rehabilitation counselors, and vocational objectives became defined; vocational aptitude tests were given by the hospital psychologist as an aid in vocational planning. In short, the patients were put on a sort of pre-placement basis. Ideally, perhaps, they would have been housed in a pre-placement facility, but the hospital facilities did not permit that.

As time went on, a few of the patients did not seem to be able to tolerate the prospect of leaving the hospital and did not maintain enough improvement to continue being in the group. They were removed for the present with the promise that they would be considered again in the future when they showed improvement; new members were added.

Before the patients left the hospital, a statement about the respective responsibilities of the Vocational Rehabilitation Division and the Vermont State Hospital was worked out. A set of "house rules" was also developed, discussed with the patients, modified in accordance with their comments, and agreed to by all concerned.

On May 11, four of the patients left to assist in com-

pleting the work necessary for "opening" the house and on May 16, the remaining five members of the group joined them. Since then two girls from the Brandon State Training School, who were also rehabilitation clients, joined the group making a total of eleven with room for one more.

A member of the staff of the Vermont State Hospital visits the Rehabilitation House one evening each week to check on medication, continue group therapy sessions, and help with any problems that arise.

The rehabilitation counselor who has been assigned to work with individual patients from the hospital has worked closely with this group finding employment, helping with all kinds of personal adjustment problems, and helping prepare a personal budget for each patient. By June 1, all of the women at the Rehabilitation House had either part-time or full-time employment.

Each patient is permitted to keep a portion of her earnings each week to cover personal incidental expenses, savings (until $300 is accumulated), and the like. The balance is paid toward the cost of board and room. As soon as an individual's earnings are large enough to permit paying the full cost of maintenance and meet the expenses listed above, she pays to the Rehabilitation Division the cost of her board and room. It is expected this will not exceed $18.00 per week. Thus these patients are spared the worry of making ends meet when they first return to the community, sometimes after a stay of seven or eight years in the hospital.

The women residing at the Rehabilitation House also help with the housework and thus decrease costs. In some instances, it may be that a patient will initially work full time at the House on a job-training basis until ready to work elsewhere.

It is anticipated that after a few months at the Rehabilitation House many of the patients will be ready to leave and live elsewhere. However, the Vocational Rehabilitation Division will continue to follow these people and to provide such service as is needed until no further assistance is required. As individuals leave, other patients who have been undergoing a similar preparation at the Vermont State Hospital will take the places of those who have left.

After nine months of operation seventeen women patients had lived at Rehabilitation House, though never more than twelve at one time. Three of them had to return to the hospital, but one of these was able to come back to Rehabilitation House within two weeks. Four of the women were able to leave on outside placement or return to their homes. Currently there are ten women in residence, seven of whom have been employed for over six months and are making a gradual but successful comeback, and another has held a good job for the past month. Their average earnings are $20 a week, of which about half is used to pay their maintenance costs. A recent arrival is working as a trainee at the local library. Seven of the women are attending adult education classes in cooking, sewing or typing.

The first Rehabilitation House is located in Montpelier in order to be easily accessible to the Rehabilitation personnel who are located in Montpelier and to hospital personnel who are only twelve miles away.

As time goes on and the need continues, it is expected that similar rehabilitation houses will be established in other parts of the state. A similar facility has opened in Rutland, Vermont, for male hospital patients and boys from the Brandon State Training School who have been accepted as clients by the Vocational Rehabilitation Division, but its value has so far been limited by lack of personnel and funds.

Not only have the individuals at the Rehabilitation House been benefited by this cooperative enterprise of hospital and rehabilitation agency, but other patients at the hospital have been stimulated as well.

New Film Shows A Volunteer's-Eye View Of Hospital Care

Willmar State Hospital, Minnesota, was the locale of a 24-minute film entitled "The Human Side" produced by the Minnesota Department of Public Welfare. The film shows the state mental hospital program through the eyes of a volunteer. In the photograph at left, the hospital's superintendent, Dr. Nelson J. Bradley, goes over a scene with Mrs. Miriam Karlins (at left), director of volunteer services for the Department, and Barbara Davies, a professional actress who played the lead role.

The cast was made up of 122 volunteer workers, several staff members and two actors. The volunteers portrayed themselves and patients in the film.

The film was introduced at a gala premiere held at the Municipal Auditorium in Willmar on July 10. The festivities, which were planned by the hospital's Volunteer Council, were attended by the Governor, the Mayor, Welfare Department officials and an audience of 1200.

Wide publicity was given the premiere through on-the-spot coverage by local radio and television stations, as well as by newspapers.

Patients Take Part in Community Celebration

When the city of Hastings, Minnesota, celebrated its centennial recently, patients of the State Hospital enjoyed taking an active part in the festivities, working closely with townspeople in the preparation and execution of the historical pageant. They participated in skits, presented choral work, helped make scenery and other props.

Many patients came from the disturbed cottage, but not a single embarrassing incident marred the several weeks of patient-community collaboration. People were particularly impressed with the patients' enthusiasm and conscientiousness and approved of their participation.

William Sheeley, M.D.
Acting Superintendent

Book Club Gives Reviews

The Book Club of Larned, Kansas, is holding monthly book reviews for patients of Larned State Hospital. From ten to twenty patients attend the meetings which are held in the hospital library. Occasionally a Club member gives a talk on a hobby connected with books.

"DISCIPLINES IN MODERN PSYCHIATRIC TREATMENT"

Theme for the
FIFTH ANNUAL PSYCHIATRIC INSTITUTE

New Jersey Neuro-Psychiatric Institute
Princeton, N. J., Sept. 18th, 1957.

SIMULTANEOUS PAPERS (MORNING)

Psychotherapeutic Methods . . Franz Alexander, M.D.
Somatic Therapy . . . . . William Malamud, M.D.
Rehabilitation . . . . . Benjamin Simon, M.D.
Volunteer Services . . . . . Richard P. Swigart

GENERAL MEETING (AFTERNOON)

Panel—Developing the Community as a Therapeutic Force . . . . . Robert A. Matthews, M.D.

Participants: Charles Goshen, M.D.
Elizabeth McDonald
Max Silverstein

Panel—Viewpoints in Therapy . Nolan D.C. Lewis, M.D.
Participants: Francis Hamilton, M.D.
Sidney Malitz, M.D.
Lewis R. Wolberg, M.D.

DINNER MEETING

Common Denominator in Psychiatric Therapies
Stewart Wolf, M.D.

Reservation blanks may be obtained by writing to Robert S. Garber, M.D., Medical Director, New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N.J. Registration fee of $1.00 per person plus $1.50 for luncheon and $5.00 for dinner.

Washington Hospital Expands Educational Therapy Program

Eastern State Hospital, Medical Lake, Washington, has for a long time recognized the need for an educational program and its primary importance as a part of patients' therapy and post-hospital rehabilitation. Students have been given the opportunity to continue their education while hospitalized.

Until now, an average of 18 students a day have taken part in the 180-day school year. Five high school diplomas have been awarded as well as numerous credits at the high school level and grade school promotions at the elementary level.

The success of this program, started in the second semester of 1954, justifies the expansion now in progress. Thanks to funds made available by the Department of Public Instruction, a supervisor of education and one new teacher have joined the staff. Two classrooms, an office, a library-study hall and storage space, adjacent to the present classroom, are now under construction. Supplies, books, and classroom material are being purchased.

Under the expanded program, which will provide the same courses as those given in public schools, it is anticipated that a minimum of 20 students per day will be in attendance, since all juvenile patients mentally and physically able to attend school will be required to do so in accordance with school laws of the State of Washington.

Systematic Maintenance Pays

By O. D. D. EWING, Maintenance Engineer
Winfield State Training School, Kansas

UNTIL RECENT YEARS maintenance was considered a handy man's job. Today it is big business. Administrators have found that without proper maintenance programs, the entire organization can approach total breakdown. The mental hospital administrator knows that it is difficult to establish what he calls a "therapeutic atmosphere" in an old, broken-down, dirty building in which even a well person would become depressed.

A good maintenance program cannot be obtained as a package deal. It must be planned to fit the hospital, the type of patient and the purpose of the hospital. In a hospital for the mentally deficient, for instance, maintenance bears a very heavy burden. The patients have childlike mental capacities but a fully adult physique, and damage to property can be severe. In hospitals treating the mentally ill, the destruction is not so severe, and there is not such a heavy load in actual repairs and replacements.

But in any hospital, the maintenance program should be carefully initiated and planned. The first step in setting up such a program should be a complete survey of the premises. This survey should be made in the company of the supervisory employees of each department. Notations made during the initial inspection, together with the recommendations of the supervisors, should be the basis of the overall maintenance program. Priorities must be established from this survey to determine a continuous maintenance schedule.

Because availablity of funds is basic, the program will have to be set up in sections: special projects for which funds have already been appropriated; projects to be completed from operating funds; projects for which funds must be requested; and finally, special maintenance on a monthly or seasonal basis. Routine maintenance operations should not be included in these four special sections.

Monthly Schedules Made

Once a long-range program and schedule are formulated, monthly schedules can be built in accordance with critical priorities. Such a program should not be established for a period shorter than six months. The schedules will be worthless unless they are followed faithfully and the accomplishments faithfully reported.

There are always unscheduled maintenance needs, and such work is handled by work order. The work order is initiated by the department supervisor and should be approved by a designated authority to avoid unreasonable, impractical or overcostly requests. Such channelling is a good insurance against the abuse of work-order privileges.

Naturally maintenance will only be as good as the supervision, maintenance personnel, tools and equipment will permit. The personnel problem is of major importance, and wage scales are usually a determining factor. Only by paying proper wages can the institution obtain the most desirable mechanics, who will save money in the long run.

However good the personnel hired, proper training and orientation of maintenance personnel is vital. In-service programs for the maintenance people, together with conducted tours and orientation courses in the total work of the hospital, are just as valuable for them as for any other staff members. Unless there is some understanding and acceptance of the inner workings of other departments there is little hope of interdepartmental cooperation.

The simpler the planning the smaller the cost, of course, yet there is need for certain records. Inventories of materials and stocks are essential. The lower this inventory can be kept and yet afford the needed basic materials, the better. Records of material used and the labor cost help a lot in future planning and budgeting. Reasonable realistic estimates cannot be made if there are no precedents. Service records on equipment, machines, structures and buildings should be kept, so that the proper time for lubrication, repair or replacement can readily be determined.

This leads to the subject of preventive maintenance. Such a program is based on the fact that if periodic inspection, lubrication and other needed procedures can be maintained, observation will indicate that breakdown or complete deterioration can be delayed by corrective measures taken early enough. It is easier and cheaper to replace minor parts than to replace the whole.

All employees should be encouraged to assist the preventive maintenance program by reporting damage of property, poorly operating machines and equipment and other difficulties to the engineer as soon as they are observed.

Planning for Painting

In mental hospitals especially, the painting program is a large item. Maintenance costs and labor can be held to a minimum by using the best

quality materials. In choosing paint, coverage, washability, toxicity and fire resistant qualities should be considered. A request to the psychology department about the colors to be used for wards, day and play rooms will always bring a variety of color prescriptions. If appropriate colors, helpful to the patients, can be chosen in advance, the paint inventory can be held down. In our hospital, we keep paint records so that we can duplicate or match a color even if it has faded. We are able to make exactly 1322 separate colors and 17 woodstains—all without guess or trial mixing!

Locks are a recurrent headache to the maintenance engineer. The administrator who prescribes the installation of a universal lock system will get better results than if he prescribes aspirin or tranquilizing drugs for the engineer.

Emergency or stand-by planning must not be overlooked. The maintenance department is responsible for immediate activation of emergency equipment in case of fire, flood, tornado or hurricane. Periodic testing and trial runs of the needed equipment are desirable, because it will be useless when the time comes if it is not in good working condition. Protective and easily accessible storage places are also of great importance. Practiced, planned procedures and communications enable the equipment to be put to the maximum use. Every member of the maintenance department should be trained in its use.

Loan Library Additions

Please enclose 10¢ for each one-pound volume and 14¢ for each two-pound volume to cover postage and handling.

WARD MANUALS AND TRAINING OUTLINES

Physicians' Manual *(B.C., Provincial Mental Health Services)* *2 lbs.*

O.T., R.T., ADJUNCTIVE THERAPIES

Recreation Department Manual *(Southern Wisconsin Colony and Training School, Union Grove)* *1 lb.*

MEDICAL RECORDS AND ADMINISTRATIVE PROCEDURES

Preventive Maintenance is You *(Arkansas St. Hosp.)* *1 lb.*

MENTAL DEFICIENCY

Policies, Programs, and Possible Future Plans for the Mentally Retarded in the Ten Northeastern States *(M. A. Tarumianz, M.D. and H. A. Davis, Ph.D.)* *1 lb.*

Polk Papers *(Polk State School, Pennsylvania)* *1 lb.*

MISCELLANEOUS

The Hospital and Medical Facilities Construction Program *(Under Title VI of Public Health Serv. Act)* *1 lb.*

Revised Master Menu Manual for Use in State Institutions. *(Prepared by Louis A. Luker, Food Admin.—Dept. Public Welfare, Illinois)* *4 lbs.*

Civil Defense and Disaster Plan *(N. J. St. Hosp., Greystone Park)* *1 lb.*

Disaster Plan *(Patton, Cal., St. Hosp.)* *1 lb.*

Manual of Procedures, Topics, and Materials for Discussions in Mental Health *(Natl. Acad. Religion and Mental Health, N. Y.)* *1 lb.*

Policy Book *(Boston, Mass., State Hospital)* *2 lbs.*

Employees Learn Economy Through Cost Data

The quickest, easiest method is not always the most practical. At the Richmond State Hospital, Indiana, cost accounting is not part of the duty of the bookkeeping or budgeting staff. It is done by the inventory clerk and contains much more information than just financial statistics.

The Inventory Department began, in 1955, to combine cost accounting figures, inventory statistics, alphabetized lists of supplies, brand names, weights, measures, sizes of vendors' packing methods and other miscellaneous information all on the same sheet of paper. Reports on drugs, food, household, cleaning and laundry, and textile supplies are compiled each month, containing all the above information. Seven copies are made of each report. The top copy is mailed to the State Inventory Control Division, the second copy is retained in the Inventory Department, the others are distributed to any department having need for such information.

We believe that by giving all employees free access to this compiled information on what we use, why and how it is used, and letting them read the actual costs of operation and consumption, they will gain an interest in the supplies they use and this interest will give them a feeling of responsibility and respect toward supplies and equipment, causing them to become less wasteful.

Many good, dependable employees who honestly desire and try to do their best are actually raising the costs of operation and consumption through their well intended but misguided efforts to economize. We believe this is due to lack of knowledge about the supplies furnished, their cost, and the best methods of usage. The same applies to equipment; if employees are informed of the original cost, subsequent operational and repair costs, they will treat such items with more care.

Authorities of institutions would do well to recognize these many small but costly leaks in their budgets and turn them into a well directed course toward future economy by making all cost accounting and inventory statistics freely accessible to all employees.

The category on food supplies offers a good example. The monthly report on food combining inventory balances, usage figures, cost accounting and other information goes to the dietitian to assist in tasty but economical meal planning. A copy goes to the purchasing department, helping to stabilize and economize on food buying. A copy is sent to the warehouse clerks to help them in caring for, rotating and controlling stock disbursements relative to amounts on hand. This also shows them the actual financial losses due to spoilage and damage caused by careless handling. The cost accounting on this report also enables the budget staff to adjust future needs to available finances. An available monthly per capita cost figure is also derived from this food report. The extra time and work involved in this method is of small consideration compared to the benefits derived.

EVELYN AMMON
Inventory Clerk

Methods of Debt Collection Help State Hospital

State mental hospitals as a whole were for many years lax in prosecuting collection of the statutory charges for maintenance, care and treatment. This attitude produced a certain small group of debtors who fell into the habit of disregarding communications from state hospitals.

Collection aids offered by professional collection agencies have not always been suitable or economical for use of these hospitals. Such hospitals, nevertheless, continue to mail regular printed statements. The routine nature of the notices occasionally causes these debtors to utterly disregard them.

An effective way to bring the matter to the attention of the debtor is to make a brief, courteous notation in a prominent place on the bill either by rubber stamp impression or with the attachment of a small slip of paper. The use of these means usually will elicit a reply where no remittance is made because the debtor begins to suspect that an active collection effort is about to commence.

A majority of debtors dislike letter writing. By way of assistance, brief form letters have been prepared at Topeka, Kansas, State Hospital with multiple-choice answers. These accompany the statements. They have brought numerous acknowledgments where the debtors otherwise have been totally ignoring the billing.

E. C. WESTLUND
Fiscal Officer

Employees' Credit Union Saves Time, Improves Morale

In May, 1942, a half dozen members of the staff of the Provincial Mental Hospital at Essondale, B. C., met to plan the formation of a Credit Union whose membership would be restricted to hospital staff. As a result the P.M.H.E. Credit Union was duly incorporated on May 26th of that year.

Management was sympathetic to the movement and provided office space and later incorporated into their new public services building a spacious, modern office with fireproof vault for the Union's use, rent free. As a large percentage of the staff's financial transactions and problems can be completed on the grounds, time loss and absenteeism are eliminated to a considerable extent.

The general policy of the Union's directors and officers is to provide as much service and advice to members as possible; many a knotty financial problem has been solved through the consolidation of multiple debts and financing through the Union. A strong campaign for savings and financial security is constantly carried on. It is believed that this policy has resulted, in many instances, in happier and more contented staff members.

Since incorporation the Union has served the needs of its members through loans totalling over $2,375,000.00. Present assets total $662,550.00 and current loans $597,300.00.

P. B. RICHARDS,
Credit Union Manager

EMPLOYEE UNIONS: *Pro and Con*

UNIONS CAN BENEFIT HOSPITAL OPERATION

By JACK EWALT, M.D., Commissioner, Department of Mental Health, Boston, Mass.

MANY SUPERINTENDENTS regard unions or employees' associations as a threat—and they have union trouble! Others, more progressive, have a well-organized union, high morale in their institutions, and frequently, union members fighting battles for them to help get better standards of patient care.

Only employees who feel that they are important, and have status in the hospital do much toward improving patient care. For this reason I firmly believe in doing and allowing everything possible to upgrade the employees' status. Belonging to a union, being a steward or an officer of the union, being on the grievance or promotions committee increases a man's identification with his job and increases his sense of status.

I do everything possible to foster the smooth operation both of the union and the employees' group; I spend considerable time myself and have my staff spend time in helping them to grow and train their workers. In the beginning, every association and every union spend a good deal of time hollering about rights. This is usually because of minor annoyances, and sometimes due to actual maladministration. But by working with these groups you can often get them very much interested in promoting patients' welfare. For example, in one of our hospitals, the union took the initiative in starting a new auxiliary, and through the joint participation of the union and the employees' group provided the patients with television sets and other things.

True, the formation of such groups does bring minor administrative headaches. But the improved sense of status, the higher morale and the sense of participation in an active union more than outweigh the annoyances and challenges to authority that unions sometimes cause.

Many superintendents are disturbed because an employee with tenure who is threatened with dismissal will be defended by an attorney employed by the union. This is true whether the union does or does not believe that the man has a valid case. Yet everybody, if he is accused, is entitled to adequate defense. This sense of security and having a fair shake rather than being subject to capricious dismissal because of a grudge or because of favoritism does much to improve employee morale. Such improvement in morale is worth almost any price.

Pro

While my views differ somewhat from those of many of my contemporaries, I speak out of some experience in Massachusetts. In Massachusetts we have a State Employees' Association that involves many of the staff of my department. Secretaries, police officers, janitors, nurses and almost anyone may belong to this very active organization. In addition, the American Federation of Labor, the Council on State, County and Municipal Employees each have union groups in each of our seventeen hospitals. These unions are somewhat smaller than the State Employees' group, probably because they are new, but they are rather more active. There is some competition between the unions and the Employees' Association, but they cooperate on most major issues.

An interesting example of how the unions have been supporting our own efforts has been in the attempt to work out a better pay scale for our professional and non-professional personnel. The Massachusetts section of the A. F. of L. is attempting to interest the national group in this endeavor. It is possible that one day we may have to have federal subsidy because so much of the tax base has shifted from the local to the federal level, and there isn't enough money at most state and county levels to support state and county hospitals adequately. If the National group of the A. F. of L. does get interested and help push our endeavors, federal subsidy would be a long step forward in providing adequate care for our patients.

Moreover, I believe that at least part of the boost in the Federal Research Program came from letters written by unions to influential representatives, who decided that this part of the budget needed fattening up. I am not saying that union letters were the only factor, as there were many other pressures, but Congressmen and Senators often give careful attention to letters from the A. F. of L. and I am sure they did no harm.

I would recommend that every superintendent or commissioner do everything possible to subsidize the formation of employee groups or unions and do everything possible to educate union leaders to be responsible persons, taking an active and democratic role in the operation of the hospital. Good superintendents need not feel threatened by any demands, disagreements or problems brought to them by their employees.

UNIONS IN HOSPITALS ARE WRONG AND UNNECESSARY

By GRANVILLE L. JONES, M.D., Superintendent, State Hospital, Little Rock, Ark.

WHAT IS WRONG WITH UNIONS? This can be answered quite simply: They are wrong because they divide loyalty and they take over power without administrative responsibilities.

Trade Unions are not inherently bad. They are good, they are useful, and perhaps even necessary to balance the scales between workers and management, when the corporate structure is based on private financing. The power of capital, unchecked by the power of organized labor, has tended in the past to exploit and victimize the worker. When, however, the ownership of the institution is by the taxpayers, and the administration of the institution is the extension of the arm of government, unions are definitely and wholly out of place.

What can Unions get for members that other hospital employees ought to have and cannot get? In a public institution, wages, hours, working conditions, leave policies—all of these and many more—are established by law or governmental regulations not subject to collective bargaining or negotiation. Promotion in any organization should be on merit, and work assignments should be based on the needs of the institution. If the union can gain preferential treatment for its members over the non-union employees, something is sickeningly wrong with the administration.

If the institution is under Civil Service, machinery for taking care of grievances is certainly provided. If there is no Civil Service, there is no reason why the mechanism cannot be created by the administration without any need whatever for the intervention of a labor union. If there is nothing to be gained by belonging to the union, why should employees pay dues? I am opposed to the concept of the union shop in governmental service, and I am bitterly opposed to having one group of employees obtain benefits not shared by others.

Dr. Ewalt speaks of union membership bringing more "status". Why should union membership confer more status than employment in an altruistic service in a good public institution? Should not management of the institution be so structured that the employee would find the work itself rewarding enough? Why would not the employee's loyalty be diluted by belonging to an organization not primarily concerned with the purpose of the institution itself? I doubt that belonging to an organization which is inherently and necessarily selfish in its motivation can bring any greater feeling of importance than employment in a hospital operated by a great state for the benefit of sick people. A good superintendent can foster a feeling of participation by many devices, such as special committees, service awards, planning sessions, the publication of a house organ, in-service training programs—in other words, all of the elements of good personnel practices. I do not believe that the unions have a special magic not shared by good administrators.

Con

One certainly does not need a union in order to establish a hospital auxiliary. If you do not have a mental health association to start one for you, the American Red Cross has a local chapter in your neighborhood, and there is no better volunteer organization, to my knowledge, than the Red Cross Gray Ladies Corps. There is a real advantage in having a volunteer organization, be it auxiliary or Gray Ladies, based in a citizens' movement open to all.

There is nothing wrong with an employees' association organized for self-improvement, for social activities, for recreation, or for the purpose of presenting the hospital's story in a favorable light to the public. However, there is objection to an organization which has as its purpose the taking over of power in the hospital without authority or administrative responsibility. Some articles recently published in the magazine "PSYCHIATRY",* by Cumming and Clancy, describe the evils of such arrogation of power by people within the hospital outside of the administration.

Dr. Ewalt concludes by the statement: "Good superintendents need not feel threatened by any demands, disagreements, or problems brought to them by their employees." I could not agree more wholeheartedly with this statement, but I certainly disagree with his conclusion that this means we should go out of our way to create demands, disagreements or problems by fostering the establishment of a union. The "benefits" from unions can be gained by good personnel practices without the undesirable features heretofore mentioned. His characterization of the headaches brought on by unions as "minor" is a striking understatement. In a hospital which I know well, things were moving smoothly until a union was established. A feeling, factual or not, by non-union employees that the members were getting preferential treatment, led to the establishment of a competing union; in addition to the struggle for power between unions and management there was a struggle between two unions. The results were disastrous.

I resent, and I believe many other superintendents will resent, the implication in the opening statements by Dr. Ewalt in which he says that to be a progressive superintendent one must favor a union. This is his opinion and should be labeled so; it certainly is not, in my opinion, a fact.

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* *Cumming, Elaine, Clancy, I.L.W., and Cumming, John. Improving Patient Care through Organizational Changes in the Mental Hospital, PSYCHIATRY, 19: 249-261.*

The Locus of Power in a Large Mental Hospital. 19: 361-369.

PSYCHIATRIC AND DETENTION WINDOWS

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ARCHITECTURAL
Feature
Of The Month

THE CHILDREN'S UNIT
of Eastern Pennsylvania Psychiatric Institute

By ROBERT C. PRALL, M.D.
Director, Children's Service
Eastern Pennsylvania Psychiatric Institute, Philadelphia

THE CHILDREN'S UNIT of the Eastern Pennsylvania Psychiatric Institute is a 50-bed residential facility and outpatient clinic for the treatment of emotionally disturbed children and their families. Upon these treatment programs are based the extensive research and training programs for which the Institute was created.

The Institute, which is under the direction of John E. Davis, Jr., M.D., was established by an act of the Legislature of the Commonwealth of Pennsylvania and was dedicated on May 16, 1956 to the purposes of research, training and healing in the field of mental health. In addition to the Children's Unit, the Institute contains an adult unit with 250 beds, a large adult outpatient clinic, a department for research in the basic sciences related to mental health, and all the necessary maintenance facilities.

As set forth in the enabling Act, the Institute is located in the immediate vicinity of one of Philadelphia's five medical schools with which it is affiliated, and within easy traveling distance of the remaining schools. The Medical Advisory Board of the Institute is composed of the five professors of psychiatry, and the Board of Trustees includes representatives of these medical schools. Administratively, the Institute is responsible to the Department of Welfare of the Commonwealth of Pennsylvania, which supplies the operating funds.

Architects for the Institute were Harbeson Hough Livingston & Larson and Harry Sternfeld, of Philadelphia.

The photograph above shows the rear of the Institute; the Children's Unit occupies the wing at the right.

TRAINING PROGRAM

In view of the tremendous shortage of trained personnel in all the disciplines working with disturbed children, an essential part of our program is focused on training a large number and variety of people.

(1) Psychiatrists: Residencies in child psychiatry are available to psychiatrists who have completed their training in basic psychiatry. This is a two-year training program in which the psychiatrist develops, under the supervision of the training staff, skills in the diagnosis and treatment of disturbed children and their families,

The entrance to the Children's Unit faces onto the same curving driveway as the entrance to the Institute proper. Inside, the lobby is furnished with both regular and child-sized furniture. Behind the counter (above), where Dr. Prall is seen talking to the receptionist, is the stenographic pool.

familiarity with community resources and educational facilities, and the operation of the various disciplines included in the therapeutic team. Residents in adult psychiatry from the Institute and others from adult psychiatric training programs are offered an opportunity to work in the Children's Unit for various periods of time so that they may become familiar with some of the problems and the methods employed to solve them.

(2) Social Workers: Social work students from nearby schools of social work will be given an opportunity to work with the parents of disturbed children under the guidance of highly trained personnel to learn the role of the social worker in the therapeutic team.

(3) Psychologists: Trainees in clinical psychology are afforded closely supervised experience in their role as members of the team and in the use of psychometric and projective test materials.

(4) Child Care Personnel: An inservice training program is provided for child care and nursing personnel who work in the residential units with the children.

The other members of the team include teachers and occupational therapy workers. Plans for student placement in these disciplines are also underway.

RESEARCH

The research program is an integral part of the clinical functioning in both the inpatient and the outpatient departments of the Unit. In addition to the participation of the clinical staff in the various research projects, a specialized research staff has been assigned to the Children's Unit.

A close collaboration with the research departments of the Institute, with their extensive laboratory facilities, makes it possible to extend the scope of our research investigations. In general the research interests include sociological, biochemical, psychological, psychodynamic and psychotherapeutic approaches to a variety of emotional disorders of childhood.

The research and training programs in the Children's Unit determine the intake.

STAFF PATTERN

All the various professional disciplines work together as a coordinated team, with each person carrying out his separate function; integration is accomplished by means of team meetings and conferences.

The table of organization calls for seven child psychiatrists, nine social workers, six psychologists, two teachers, two occupational therapists, one aide, and one pediatrician. There are 53 nurses and child care workers assigned to Children's Unit, and three unit coordinators.

In addition there are four part-time consultants who participate in the training program and offer advice regarding research.

CLINICAL PROGRAM

In the treatment programs offered to the families of the disturbed children who are referred from the various community agencies, the emphasis is placed on meeting the individual needs of the child. Each child who is referred is given a careful diagnostic evaluation on an outpatient status by means of psychiatric, psychological and sociological evaluation of his family and cultural setting.

After this careful diagnostic evaluation, the appropriate method of treatment is decided upon and offered to the family at a Family Conference. The fee which the family pays is determined by their income and number of dependents, based on a sliding fee scale. The services of the Institute are available only to residents to Pennsylvania.

Depending on the nature of the patient's problems, treatment is offered on an outpatient basis, a day-care basis, or 24-hour residential treatment.

Outpatient Unit: In addition to the diagnostic screening of all cases just described, the outpatient unit offers treatment to a variety of disturbed children who are able to remain at their home during treatment.

Psychoanalytically-oriented therapy is emphasized in this unit for the wide variety of disorders found in chil-

dren of all ages. The large caseload offers the variety of clinical case material necessary for training purposes. Specialized research data is also collected on the outpatient cases in reference to certain specific research projects.

Day-Care Program: One of the unique features of the clinical program is the flexibility it provides for other forms of treatment when indicated. If the staff feels that outpatient treatment cannot meet the individual child's needs, more intensive treatment can be offered in a day-care program.

Before admission to residential treatment, a gradual process of orientation is instituted for the child by means of the day-care program. After the child feels comfortable and familiar in the new surroundings, he may be admitted to the residential unit on a 24-hour basis in accordance with his treatment needs.

Inpatient Unit. When the child comes into the residential unit his needs are met by the unit staff, which includes the psychiatrist, the social group worker who serves as "unit coordinator," and the nursing and child care personnel who work with the children on three eight-hour shifts. To create a more home-like atmosphere for the children, the staff do not wear uniforms and food is served family-style in a relaxed atmosphere.

We have found it necessary to separate the older and younger children during meals, and have converted the second floor visiting room into a small dining room for pre-school age children. Most of the disturbed children have tremendous problems centered around eating and it was found that when the older and younger children had meals together, a disturbed mealtime situation was created.

In order to provide coverage of the smaller residential areas on three shifts, the following staff pattern for nursing and child care personnel has been set up: Day shift 6; Evening shift 5; Night shift 3. There is a nursing supervisor on each shift.

On the larger residential areas, approximately the following number of personnel give full coverage: Day shift 8; Evening shift 9; Night shift 3. These also have a nursing supervisor on each shift.

The two larger residential areas, with beds reserved for emergency purposes, can accommodate fourteen to fifteen children each. One 4-bed room was converted into a rumpus room; additional play area was needed in order to allow for sub-grouping during activities and to make up for the absence of a gymnasium of our own, which would have been desirable. The present arrangement of sharing the gym (which also serves as an auditorium) with the adult unit is inadequate. During bad weather, when indoor play space is necessary, the gym is often unavailable.

PHYSICAL STRUCTURE

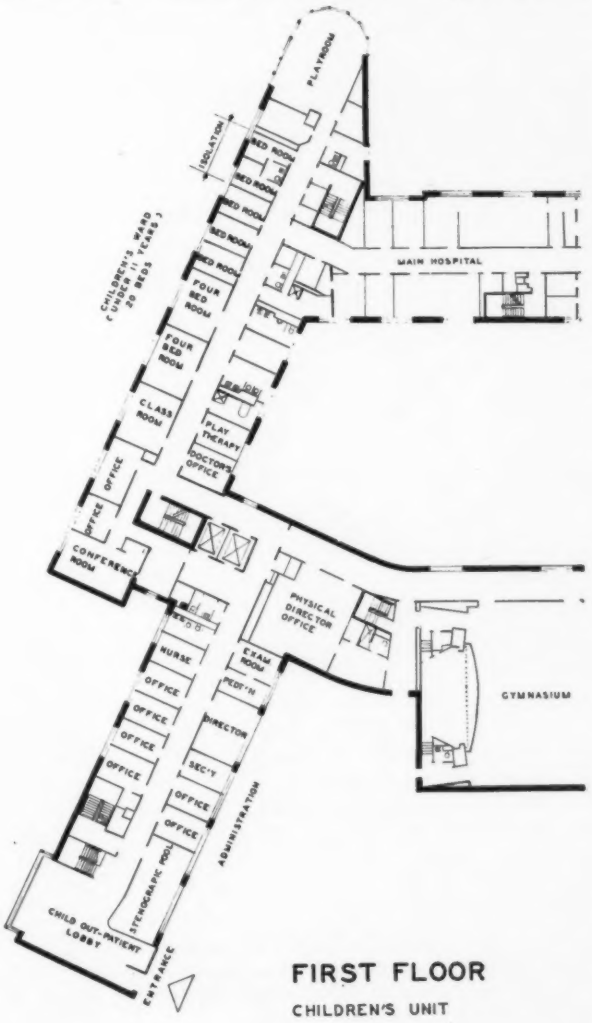
As one approaches the Institute it is apparent that the Children's Unit is a separate structure with its own entrance, and yet is closely attached to the main building of the Institute by means of corridors. This unit consists of three floors and a basement. Because of the lay of the land, the unit is entered via the Outpatient Lobby on the first floor.

Entering this large waiting room one sees several children waiting for appointments, and a parent arranging for appointments at the receptionist's desk. Behind the receptionist's desk is the typing pool with automatic dictating equipment to which each telephone throughout the unit is connected. Along the main corridor are the offices of the Director and the department heads, and the pediatrician's office and examining room.

Beyond the elevators is the entrance to one of the corridors through which there is ready access to the complete diagnostic and treatment facilities of the whole Institute which include X-ray, electroencephalograph, electrocardiogram, physical therapy, bio-chemical, clinical and basic research laboratories (not shown in plans).

The remainder of the first floor is occupied by one of the three children's residential areas. This one contains 20 beds for children under 11. Bedrooms in all areas are arranged to accommodate one, two or four children, and the children are grouped according to age, sex and sleep patterns.

Along one side of this residential area are three 4-bed rooms (the room marked classroom on the floor plan has been converted into a 4-bed dormitory), and three



FIRST FLOOR
CHILDREN'S UNIT

The second-floor schoolroom (not indicated on the floor plan) adjoins the residential area.

SECOND FLOOR

CHILDREN'S UNIT

Dining is family-style, in small groups; this helps not only to keep order at mealtime but also to keep the atmosphere and relationships as "non-institutional" as possible. In keeping with this philosophy, the personnel wear regular street clothes.

The nursery playroom has a skylight to augment the indirect lighting. Staff members can prepare snacks for the children in the kitchenette seen through the doors at far end of the room.

2-bed rooms, as well as two single bedrooms with private bath. On the side opposite the bedrooms there is a play therapy room with terrazzo floor and running water, a locker room for the children's clothing, shower and bath rooms. At the far end is the utility room and nurse's station, which looks through on the attractive, light and airy day hall—the children's living room—where they play and spend their leisure time. A built-in refrigerator and hot plate on each floor provide bedtime refreshments for the children.

Adjoining the residential area are a visiting room, the offices of the ward psychiatrist and the "Unit Coordinator" (a social group worker) who serves as administrative assistant to the ward psychiatrist. The Conference Room at the lower end of the corridor has a specially constructed one-way-vision window between it and the adjacent office. Through it, groups of students assembled in the Conference Room can observe therapy being conducted in that office, films and recordings can be made unobtrusively, and the like.

A trainee observes a therapy session through the one-way-vision window in the Conference Room.

All children in photographs are the children of staff members; no actual patients are shown. Photographs of playroom (above right), dining room and nursery playroom (opposite page) and lobby (p. 30) were taken by Courtland Hubbard.

The playrooms are spacious and sunny, having large expanses of window. They are equipped with blackboards, posterboards and toys appropriate to the age group on each area. The close-up at left shows the window (above shelving) through which personnel in the adjoining nursing station can keep an eye on the children in the playroom; note the wash stand in the corner.

Directly above, on the second floor, is a similar area of 20 beds for adolescent boys. Opening on to this area is the Institute's occupational therapy department, which provides sewing, art and metal and wood work and ceramics for older children. Over the administrative wing and waiting room, there is a smaller unit which has ten beds for adolescent girls. One bed here is kept open for emergencies such as the isolation of a child, or for the use of a child who has just returned from an extended leave.

Between these two residential areas are the dining room, kitchen, visiting room and nursery playroom. Sponge rubber inserts on the doors in this area prevent the possibility of the children pinching their fingers. Food comes from the central kitchen of the Institute in an electrically heated steam table which is plugged in the kitchen on this floor, thus avoiding the necessity of transferring food to another steam table.

Two schoolrooms are provided. One is located adjacent to the second floor residential area and the second on the ground floor near the elevators. Also on the ground floor are staff conference rooms and twenty offices occupied by social workers, psychiatrists and psychologists. Two of these are equipped with running

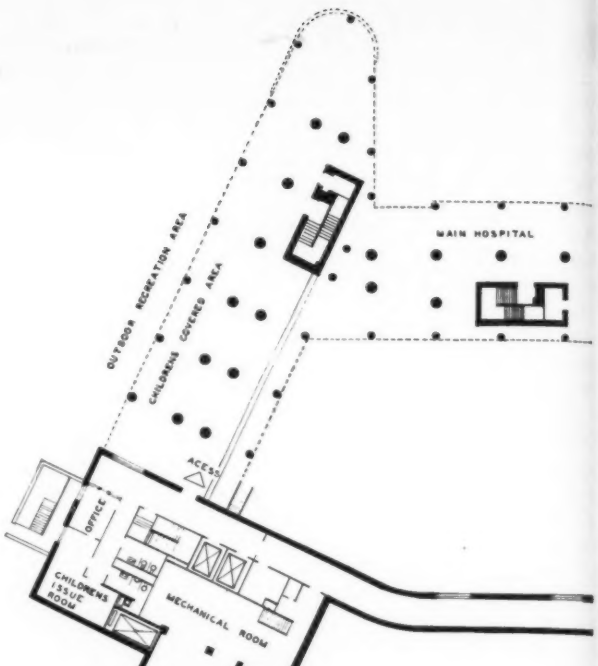
water and terrazzo floors similar to the playrooms in the residential areas. The Children's Unit occupational therapy department, for the younger children, is on this floor. At the end of the corridor there is a day hall with blackboards and bulletin boards, which is almost identical to the day halls on the other two floors. This day hall is often used as an additional classroom, conference room, or for other group activities. There is a small Pullman kitchen in this room, which increases its usefulness.

The lowest level (see Basement Plan) houses the storeroom for outdoor recreational equipment, such as bicycles and rollerskates. The entrance to the children's protected play yard is on this level. Because the building is situated on sloping land this play area is below the street level and is not visible from the front of the building. Included in the playground facilities is a cement-paved play space beneath the overhang of the upper floors.

While the building is quite modern and has been carefully planned, in actual use we have discovered some disadvantages in this type of structure. It might be well

GROUND FLOOR

CHILDREN'S UNIT



BASEMENT

CHILDREN'S UNIT

to mention a few of these disadvantages for those who may be considering the development of this type of facility.

Access to the ground floor classroom and occupational therapy shop, as well as to the play area on the basement level, is somewhat difficult since children must be transported on the elevators from the living areas. This requires a larger number of staff to prevent the children from wandering into other parts of the hospital, and into the staff offices and conference rooms on the ground floor. A one-story structure, without elevators, would eliminate some of these problems and would provide the advantage of ready access to the outdoor play area.

One of the mechanical disadvantages which has become apparent is the acoustical problem which arises from the cinder block and concrete construction. Speaking voices are readily conveyed between offices and sound resonates markedly in conference rooms and day halls. In addition, a large amount of outside noise from neighborhood factories and railroads creates problems, especially in the summer when the windows are open. Air conditioning, which would permit the windows to remain closed, and acoustical tile would in some measure reduce the noise.

People & Places

NEW YORK: On July 1, **Dr. Arthur G. Rodgers,** director of Binghamton State Hospital, became director of Syracuse State School . . . **Dr. Ulysses Schutze,** assistant director of Central Islip State Hospital, succeeded him at Binghamton . . . **Dr. Charles Greenberg,** director of Craig Colony, Sonyea, became senior director of Rome State School and was replaced at Craig Colony by **Dr. William C. Johnston,** formerly assistant director of Matteawan State Hospital . . . **Dr. L. Laramour Bryan** was appointed assistant commissioner of Mental Hygiene and **Dr. Helen C. Elliott,** former assistant clinical director at Central Islip State Hospital, deputy assistant commissioner, both in the Department of Mental Hygiene in Albany . . . **Dr. O. Arnold Kilpatrick,** director of Hudson River State Hospital at Poughkeepsie since 1950, died in March. He was replaced, on September 1st, by **Dr. Robert C. Hunt,** previously director of the Erie County Community Mental Health Board in Buffalo. KENTUCKY: **Mr. Siegfried H. Ries** is now personnel officer of the Department of Mental Health. He replaced **Mrs. Mary Stuart Wedekind** who had been Personnel and Legal Officer of the Department since 1952 . . . **Dr. Milton M. Green** became Acting Superintendent of Western State Hospital, Hopkinsville, following the resignation of **Dr. Jekabs Knezinskis,** who joined the staff of the VA Hospital at Brockton, Mass. MASSACHUSETTS: **Dr. Winthrop Adams,** manager of Bedford VA Hospital for 27 years, retired last May after 38 years of service in VA. . . . With the opening in May of the H. Edward Manville Building, the Judge Baker Guidance Center in Boston is offering residential treatment for emotionally disturbed youngsters. The new unit will accommodate 30 adolescents ranging in age from approximately 11 to 17. The residential program supplements the outpatient and clinic work the Center has conducted for 40 years. WASHINGTON: **Dr. Robert H. Dickinson,** formerly associate professor of psychiatry and coordinator of clinical services at the University of Chicago Medical School, was appointed medical director of Pinel Hospital, Seattle. He replaces **Dr. Stanley Jackson,** present acting medical director who is entering private practice. . . . A former medical director of the institution, **Dr. J. Brooks Dugan,** died in California last May, where he had gone into private practice. . . . MARYLAND: **Dr. Joseph M. Bobbitt** has been appointed assistant director of the National Institute of Mental Health. . . . Perry Point VA Hospital has a new manager: **Dr. Lee G. Sewall,** formerly manager of the Leech Farm VA Hospital in Pittsburgh.

New M.H.S. Consultants Appointed

A.P.A. President, Dr. Harry C. Solomon has appointed Dr. Walter Rapaport of California and Dr. Rupert A. Chittick, the Superintendent of Waterbury, Vermont, State Hospital, to the Board of Consultants of the Mental Hospital Service.

Dr. Chittick is chairman of the A.P.A. Section on Hospitals for the 1958 Annual Meeting.

PROGRAM TOPICS AND LEADERS FOR NINTH MENTAL HOSPITAL INSTITUTE

September 30th through October 3rd, 1957
Hotel Cleveland, Cleveland, Ohio

LAYING THE FOUNDATIONS FOR AN OPEN MENTAL HOSPITAL
Francis T. O'Neill, M.D., Central Islip, N. Y.

NEW TYPES OF HOSPITAL-COMMUNITY FACILITIES
H. E. Lehmann, M.D., Montreal, Canada

LEGAL IMPLICATIONS OF THE OPEN HOSPITAL
Henry A. Davidson, M.D., Cedar Grove, N. J.

LOCAL PUBLIC HEALTH SERVICES AND THE HOSPITAL
Robert H. Felix, M.D., Bethesda, Md.

COMMITMENT LAWS ARE IN URGENT NEED OF REVISION
Manfred S. Guttmacher, M.D., Baltimore, Md.

ACADEMIC LECTURE:
PRINCIPLES, SKILLS AND TOOLS OF SCIENTIFIC MANAGEMENT
Prof. James L. Hayes, New York

MANAGEMENT PRINCIPLES APPLIED TO THE MENTAL HOSPITAL
Lee G. Sewall, M.D., Perry Point, Md.

THE FALLACY OF THE PER DIEM
John J. Blasko, M.D., Washington, D. C.

INVOLVING COMMUNITY PHYSICIANS IN PSYCHIATRIC FACILITIES
Robert A. Matthews, M.D., Harrisburg, Pa.

ADMINISTRATION OF RESIDENTIAL UNITS FOR CHILDREN
Thaddeus P. Krush, M.D., Omaha, Neb.

HOW THE SOCIAL GROUP WORKER MAKES INSTITUTIONAL LIFE MORE THERAPEUTIC
Raymond Fisher, Cleveland, Ohio

MANAGEMENT OF THE GERIATRIC PATIENT
Maurice E. Linden, M.D., Philadelphia, Pa.

IMPROVED COMMUNICATIONS BETWEEN HOSPITAL STAFF AND ARCHITECTS AND CONTRACTORS
Clarkson Hill, Hartford, Conn.

INVENTORY CONTROLS AND WAREHOUSING
William Brenizer, Richmond, Ind.

THE SPECIFIC FUNCTIONS OF THE PSYCHIATRIC NURSE
Ewald W. Busse, M.D., Durham, N. C.

THE ROLE OF THE PRIVATE PSYCHIATRIC HOSPITAL
Philip B. Reed, M.D., Indianapolis, Ind.

MENTAL DEFICIENCY: A PSYCHIATRIC PROBLEM
Howard V. Bair, M.D., Parsons, Kansas

THE IMPORTANCE OF SANITATION IN THE HOSPITAL
Robert Seaman, Fulton, Mo.

The closing date for pre-Institute enrollments is September 16th. The Hotel Cleveland will confirm all hotel reservations as they are received.

The Institute— and Other Matters

Enrollments for the Ninth Mental Hospital Institute are coming in earlier than usual this year. The closing date for advance registration is September 16th. Please be sure to complete and mail the reply-paid postcard to reserve your hotel accommodation. The Cleveland Hotel will confirm directly to you. It is also necessary, of course, to send the Enrollment Form to the Mental Hospital Service.

Besides the Program Topics listed on this page, several optional meetings will be held, including one for Business Managers at 1 p.m. on Sunday, September 29th, and a description of the new Children's Psychiatric Hospital in Dayton, Ohio, on Tuesday evening, October 1st at 8 p.m.

As usual the Annual Achievement Awards will be presented by the Medical Director; this year two plaques will be given: one to the Receiving Hospital, Detroit, Michigan, and the other to the Saskatchewan Hospital, Weyburn.

Another, and more unusual Award, will be made, by action of the Officers and Council of the A.P.A. to Judge David L. Bazelon of the U. S. Court of Appeals, in recognition of his famed "Durham decision."

The Executive Committee of the A.P.A., during its June meeting approved a recommendation made by the Medical Director which will have far-reaching implications for all hospital people. All central office services for mental hospitals are to be consolidated, and ways are now being explored to finance increased services to hospitals.

The first Canadian Mental Hospital Institute is to be held from January 20th through 24th, 1958, at the King Edward Sheraton Hotel, Toronto. This Institute will be patterned after our own, and staff members from the Washington office will help administer it. This first Canadian Institute has a clinical orientation and is limited for the most part to psychiatrists holding senior posts in all types of Canadian psychiatric hospital services.